Smile Hub Dental

Welcome and thank you for trusting us with your dental care. We promise to provide you with the finest care available. Please fill out all forms completely. If you have any questions, are glad to help.

PATIENT INFORMATION

Name:____ Sex:______ Birthdate:_____________________

Home Address:__________________________________ City:______________ State/Zip:_________________

Billing Address(if different):__________________________ City:______________ State/Zip:_________________

Home Phone:_____________________ Cell Phone:_____________________ Email:_______________________

Social Security #:________________________ Driver's License #:___________________________ State:________

Employer:____________________________________ Work Phone:_______________________________________

Emergency Contact:__________________ Phone Number:_____________________ Relationship:_____________

Referred to us by:____________________ Phone Number:_____________________ Relationship:_____________

INSURANCE INFORMATION

Primary Dental Insurance:______________________________ Subscriber ID:_______________________________

- Subscriber(if not patient):______________________________ Subscriber Birthdate:______________________

Secondary Dental Insurance:____________________________ Subscriber ID:_______________________________

- Subscriber(if not patient):______________________________ Subscriber Birthdate:______________________

Medical Insurance:____________________________________ Subscriber ID:_______________________________

- Subscriber(if not patient):___________________________ Subscriber Birthdate:_________________________

DENTAL HISTORY

Date of Last Dental Exam:_____________________ Name of Previous Dentist:______________________________

Have you ever had a reaction to Novocain or Anesthesia? If yes, when:______________________________________

Do you require pre-medications prior to dental treatment due to joint replacement, artificial heart valve, or endocarditis? ____

Chief complaint (reason for today's visit):____

____

Please check (✓) all that apply:

☐ Accidental injury to teeth/mouth	☐ Gum/bone recession	☐ Sleep apnea
☐ Allergy to latex	☐ Jaw pain/discomfort	☐ Smoke/chew tobacco
☐ Allergy to nitrous oxide	☐ Loose teeth/fillings	☐ Staining
☐ Bleeding gums	☐ Oral sores/infection	☐ Swollen face/cheek
☐ Clench/grind teeth	☐ Orthodontic treatment	☐ Swollen/tender gums
☐ Diagnosed with TMJ/TMD	☐ Periodontal treatment	☐ Swollen lymph nodes
☐ Earaches	☐ Sensitive to biting/chewing	☐ Tooth discoloration
☐ Enamel erosion	☐ Sensitive to hot/cold	☐ Toothache/pain
	☐ Sensitive to sweet/sour	☐ Wear dentures/appliances

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MEDICAL HISTORY

Name of Physician:_________________________________ Physician Phone #:____________________________________

Are you currently taking any anticoagulants or blood thinners? ____

Please check (✓) the following if they have ever happened:

Cardiovascular:
- ☐ Chest pain/shortness of breath
- ☐ Blood pressure problem
- ☐ Heart murmur
- ☐ Heart valve problem
- ☐ Taking heart medications
- ☐ Pacemaker

Blood Related:
- ☐ Easy bruising
- ☐ Frequent nosebleeds
- ☐ Abnormal bleeding
- ☐ Blood disease
- ☐ Anemia

Allergy:
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Taking allergy medications
- ☐ Asthma

Digestive:
- ☐ Ulcers
- ☐ Weight gain/loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems

Skeletomuscular:
- ☐ Arthritis
- ☐ Back or neck pain
- ☐ Joint replacement

Health Incidences:
- ☐ Fainting spells, seizures, or epilepsy
- ☐ Stroke
- ☐ Heart attack
- ☐ Frequent/severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough
- ☐ Swollen glands
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Tuberculosis/respiratory disease
- ☐ Hepatitis, jaundice, or liver problems
- ☐ Herpes
- ☐ STD:____________________
- ☐ HIV/AIDS
- ☐ Neurological disease
- ☐ History of head injury
- ☐ Anxiety

Drug/Material Allergies/Reactions:
- ☐ Local anesthetics
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin, Acetaminophen, or Ibuprofen
- ☐ Codeine, Demerol, or other narcotics
- ☐ Reaction to metals
- ☐ Latex or rubber dam
- ☐ Fluoride
- ☐ NO KNOWN DRUG ALLERGIES

Women Only:
- ☐ Contraceptives/hormones
- ☐ Pregnant
  If yes, delivery date:___________________
- ☐ Nursing
- ☐ Menopause
- ☐ HPV exposure

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

____

Please list all medications you are currently taking:

____

____

To the best of my knowledge, all the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Linh K. Nguyen, PLLC of any changes to my health status and/or medications.

X____ ________________________ _________________

Patient/Responsible Party Signature | Date | Dentist's Initials

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FINANCIAL POLICY

The following is a statement of our FINANCIAL POLICY which we request you to read and sign prior to any treatment. We invite you to discuss our fees or financial policies with us. We are always happy to answer any questions or concerns regarding our policies, service fees, insurance claims, or billing questions.

INSURANCE: We will be glad to submit your claim to your insurance company. To do this we **must have complete and accurate insurance information**. Please bring your insurance card, your driver's license or state ID to your appointment. **NOTE:** Your insurance policy is a contract between you and your insurance company. You are ultimately responsible for payment on all services rendered. We recommend that you contact your insurance company regarding your dental coverage, exclusions, and limitations, that way there are no surprises.

CO-PAYMENTS: All co-payments are due at the time of service.

NO INSURANCE: If you do not have dental insurance, please be prepared to pay in full at the time of service.

PAYMENT: You are responsible to pay for all services rendered (even if your insurance denies payment). Once your insurance company has processed the claim, if there is a balance due we will send you a statement. You have 30 days from the date of your statement before your account is considered delinquent. If you are not able to pay within 30 days, please call our front office to make financial arrangements, plus your account maybe assessed with interest fee of 1.5% on each subsequent statement until the balance is paid in full. We accept Visa, MasterCard, AMEX, or Discover. There is a $35.00 charge for all returned checks.

ALL ACCOUNTS OVER 60 DAYS (without prior financial arrangement): will be considered for collections. If you need additional time to pay your balance, please call our front office to make financial arrangements. If we do not hear from you and you are delinquent on your account, then you will turn over to a collection agency. The collection agency will charge their additional fees.

MISSED OR CANCELLED APPOINTMENTS: Please help us serve you better by keeping your scheduled appointments. There is a charge of $50.00 for a missed or late cancellation. We are asking for 48 hour prior notice to cancel your appointment. This will allow other patients an opportunity to come in for their care with adequate notice.

LATE ARRIVALS: We are very willing to wait for our patients for a reasonable amount of time. We ask that you call us in a timely manner with an estimate of when you can arrive, so we can adjust our time to your delay. If you are unusually late, we may have to reschedule your appointment, as to not impose on our next patient's appointment time.

I understand that I am personally responsible for all charges on all services rendered. I authorize Linh K. Nguyen, PLLC to release any information required to process my claims and I also hereby assign my insurance benefits to be paid directly to Dr. Linh Nguyen. I agree to pay all reasonable attorney fees, court costs and collection agency fees incurred by Linh K. Nguyen, PLLC if my account is turned over to Collections. I hereby agree to the terms and conditions as specified above.

____ ________________________

Patient Name Date

____

Patient/Responsible Party Signature

Welcome and thank you for trusting us with your dental care. We promise to provide you with the finest care available. Please fill out all forms completely. If you have any questions, are glad to help.

HIPAA NOTICE OF PRIVACY PRACTICES

I authorize Linh K. Nguyen, PLLC to release my general and health information along with my dental services performed under the following terms and conditions:

If you sign this authorization, you can revoke it at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is being revoked. Send this "Notice to Revoke" to our office address, email, or fax.

If you want to review or get photocopies of your health or general information, send a written request to the office. There will be a charge to photocopy and mail your information.

OUR NOTICE OF PRIVACY PRACTICES: By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by the law. If we change our Notice of Privacy Practices, the new privacy practices will apply to your health and general information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and will have copies available for you at no charge.

COMPLAINTS: If you think that we have not properly respected the privacy of health and general information, you are free to complain to us in writing to our address and we will respond to your complaint within 30 days of receipt.

HIPAA: Health Insurance Portability & Accountability Act of 1996* this Act requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally to be kept confidential. This federal law gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We can without specific written authorization: permitted to use and disclose your healthcare records for the purposes of treatment, payment and healthcare operations.

Treatment: By providing, coordinating, or managing healthcare and related services by one or more healthcare providers.

Payment: By obtaining reimbursement for services, confirming coverage, billing, collection and utilization reviews.

Healthcare Operations: By including the business aspects of running our practice, such as in training purposes or quality assessment.

In case of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health and general information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of an appointment, sending reminder postcards, or leaving messages at home or work.

We may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena, court orders, to military authorities or Armed Forces Personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, or correctional institutions or law enforcement officials and/or to report suspected abuse, neglect, or domestic violence.

You may request restrictions: on uses and disclosures of your health information to family members, other relatives, close personal friends, or any other person you identify in writing. We will abide by it until you contact us in writing to remove the restrictions.

You have the right: to access, inspect and receive a copy of your health information, with limited exceptions. A reasonable fee may be assessed. You may also receive a list of disclosures of your health information made outside of treatment, payment, or healthcare operations.

My signature below confirms that I have been informed of my rights to privacy regarding my general and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been given the right to review and receive a copy of this Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and I may contact this office for a current copy of the Notice of Privacy Practices.

____ __________________________
Patient Name Date

____
Patient/Responsible Party Signature